



ACCELERATED BENEFIT SUMMARY AND DISCLOSURE STATEMENT

EFFECTIVE DATE – The Accelerated Benefit Endorsement effective date is the same as the Policy Date shown in the Policy Schedule.

PREMIUM – There is no additional premium charge for this Endorsement.

NOTICE OF TAX CONSEQUENCES – The accelerated benefit of this life insurance policy may provide benefits to pay for long-term care services but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays may not be enough to cover your medical, nursing home or other bills. You may use the money you receive from this policy for any purpose. Unlike conventional life insurance proceeds, accelerated benefits payable under this Endorsement **COULD BE TAXABLE UNDER SOME CIRCUMSTANCES**. We recommend that you consult your tax advisor prior to electing this benefit.

Receipt of benefits under this Endorsement may affect certain public funds such as Medicaid, Social Security and Supplemental Security Income eligibility. Contact the Medicaid Unit of your local Department of Public Welfare and the Social Security Administration Office for more information.

BENEFIT – Under the terms of the Endorsement, we will provide a lump-sum payment of this Benefit during the lifetime of the Insured if the Insured develops a terminal illness. This will be an advance on the death benefit of this Policy. Payment of an Accelerated Benefit will reduce the amount of proceeds payable to your beneficiary.

The maximum amount of accelerated benefit payable is 75% of the Death Benefit (not to exceed \$250,000) of this Policy. Benefits will not be paid more than once for any terminal illness.

ADMINISTRATIVE EXPENSE CHARGE – There is no administrative expense charge to elect this benefit.

EFFECT OF THE BENEFIT – The Policy will stay in force. You must pay any required premium when due unless premiums are being waived under a waiver of premium Endorsement. Where applicable, cash values and loan balances and paid-up insurance will be reduced in the same proportion as the amount of benefit paid under this Endorsement. The amount of insurance is the amount of life insurance coverage provided by the Policy to which this Endorsement is attached and may be defined in the policy as “Specified Amount”, “Face Amount” or “Amount of Insurance”.

NOTICE AND PROOF OF CLAIM – To apply for this benefit, You must send Us the following:

1. Your written election of this option;
2. Your written designation of us as an irrevocable beneficiary for the portion of the policy death benefit proceeds equal to the Amount of the Accelerated Benefit;
3. Proof acceptable to us from a licensed physician other than the Insured or a member of his immediate family that:
 - a. The Insured has been diagnosed as having a terminal illness; and
 - b. Such terminal illness is expected to result in death within two years.

We may require a second opinion and examination of the Insured at our expense by a physician designated by us.

We must receive a signed consent from any irrevocable beneficiaries and any assignees.

REINSTATEMENT OF ENDORSEMENT – If the base Policy terminated and is reinstated, the Endorsement may be included with the reinstated Policy, providing it was in force at the time of the Policy's termination.

Inquiries regarding this Summary should be directed to your agent, or to Us at:

**North American Company for Life and Health Insurance
P.O. Box 5088
Sioux Falls, South Dakota 57117-5088**

Unless otherwise provided in the election of this option, the Payee may neither commute, anticipate, assign, alienate nor otherwise encumber any payment under this option. Proceeds under this policy and Endorsement and any payment under this Endorsement will be exempt from the claims of creditors and from legal process to the extent permitted by law.

ACKNOWLEDGEMENT – I acknowledge that I have received and read the Accelerated Benefit Summary and Disclosure Statement that was furnished to me prior to signing the application.

Signature of Proposed Insured

Date

Signature of Proposed Owner

Date

Signature of Agent

Date



**ACCELERATED BENEFIT SUMMARY AND DISCLOSURE STATEMENT
REQUIRED AT TIME OF APPLICATION**

EFFECTIVE DATE – The Accelerated Benefit Rider takes effect on the Policy Date.

LIMITATIONS OF THE ACCELERATED BENEFIT:

The Accelerated Benefits in this life insurance product may provide benefits to pay for long-term care services but is NOT part of a long-term care or nursing home insurance Policy and the amount this product pays You may not be enough to cover Your medical, nursing home or other bills. You may use the money You receive from this product for any purpose, unless You qualify for benefits because of Chronic Illness only. If You qualify for benefits because of Chronic Illness only, You may use the benefits to pay for Qualified Long-Term Care Services only. Unlike conventional life insurance proceeds, accelerated benefit payable under this product Rider **COULD BE TAXABLE IN SOME CIRCUMSTANCES**. We recommend that You consult a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.

A. Consequences of this Benefit

Receipt of accelerated benefits **MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME (“SSI”) ELIGIBILITY**. The mere fact that You own a Policy with an accelerated benefit product may affect Your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before You apply for these programs, or while You are receiving government benefits, may affect Your initial or continued eligibility. Contact the Medicaid Unit of Your local Division of Medical Assistance and the Social Security Administration for more information.

A. Medical Condition(s) enabling accelerating of life benefit:

Chronic Illness, which means a condition because of which an individual has been certified by a Physician as:

- (a) being unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity;
- (b) having a level of disability similar to the level of disability described above; or
- (c) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

B. Benefit Payment Options:

- _____ 24% of the Death Benefit on the Initial Election Date, or \$240,000, if smaller, as LUMP SUM. This amount may be smaller for a Final Election.
- _____ Two (2) Periodic Payments, separated by 6 months.

Periodic Payment – Under a Periodic Payment, We will divide the Payment into equal Periodic Payments that will be paid in lieu of a lump sum Payment. You may choose to receive semi-annual Periodic Payments.

Since the Accelerated Death Benefit is paid prior to death, the payment received will be discounted from the amount accelerated.

A Final Election is available if the maximum Accelerated Death Benefit at the time of the Election is greater than the remaining Death Benefit in the Policy minus the Residual Death Benefit. To make a Final Election, You must choose to accelerate all of the remaining Death Benefit in Your Policy minus the Residual Death Benefit. The Payment must first be applied to pay off the Policy Debt to Us.

Residual Death Benefit – Upon the death of the Insured, We will pay the Beneficiary any remaining portion of the Death Benefit that We have not accelerated to the Owner under this Rider. If a Final Election has occurred, the Residual Death Benefit will be paid to the Beneficiary in a lump sum upon due proof of the death of the Insured. The Residual Death Benefit will be the greater of 5% of the Death Benefit on the Initial Election Date or \$10,000.

NOTE: Benefit payment amounts for Chronic Illness are payable only for expenses incurred for Qualified Long-Term Care Services.

Qualified Long-Term Care Services – means the necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services that are required by a Chronically Ill individual and are provided pursuant to a plan of care prescribed by a Physician.

C. There is no additional premium for Accelerated Benefits

D. Administrative Expense Charge: \$200 maximum for each Election.

E. Effect of the Benefit:

Accelerated Benefits paid under this Rider will reduce the Policy's Death Benefit, Specified Amount and Policy values, if any, which include but are not limited to the Account Value, Surrender Value, and amount available for loan.

You may obtain Policy loans as described under the loan provisions of the Policy. A portion of the Accelerated Benefit Payment will be used to repay any Policy Debt. Following a Final Election, Policy loans are not available.

An Election is effective for 12 months starting from the Election Date. While an Election is in effect, the Policy to which this Rider is attached will not enter the Grace Period. If the total Accelerated Death Benefits received under this Rider are equal to or greater than the Cumulative Accelerated Benefit Percentage, shown in the Schedule of Policy Benefits for this Rider, multiplied by the Death Benefit on the Initial Election Date, the Policy will not enter the Grace Period for the remaining life of the Policy.

While an Election is in effect, Partial Surrenders are not available. If the total Accelerated Death Benefits received under this Rider are equal to or greater than the Cumulative Accelerated Benefits Percentage, shown in the Schedule of Policy Benefits for this Rider, multiplied by the Death Benefit on the Initial Election Date, Partial Surrenders are not available for the remaining life of this Policy.

While an Election is in effect, You cannot elect to increase or decrease the Specified Amount or change the Death Benefit Option on the Policy. If the total Accelerated Death Benefits received under this Rider are equal to or greater than the Cumulative Accelerated Benefit Percentage, shown in the Schedule of Policy Benefits for this Rider, multiplied by the Death Benefit on the Initial Election Date, You cannot elect to increase or decrease the Specified Amount or change the Death Benefit Option for the remaining life of this Policy.

If You elect to increase the Specified Amount or change from a Level Death Benefit Option to an Increasing Death Benefit Option while this Rider is in effect, but the evidence of insurability is not satisfactory to meet the requirements for this Rider, the total Death Benefit that We will accelerate on the Policy under this Rider will be limited to the Death Benefit immediately prior to the increase or change in the Death Benefit Option.

If You have enacted a Policy provision or Rider or Endorsement, which restricts You from making any changes to Your Death Benefit, You may not elect Accelerated Benefits under this Rider. This includes any restrictions specified by a Policy provision or Rider or Endorsement, which provide over-loan protection.

Upon a Final Election, all Riders and Endorsements attached to the Policy, except this Rider, will terminate on the final Election Date. A sample illustration of the Impact of Accelerated Benefits on a Policy is given on the following page.

ACKNOWLEDGEMENT – I acknowledge that I have received and read this Accelerated Benefit Summary and Disclosure Statement that was furnished to me prior to signing the application.

Signature of Proposed Owner	Date
Signature of Agent	Date

**Sample Illustration of Impact of Accelerated Benefits on Policy Provisions For Chronic Illness
Accelerated Benefit Rider**

Immediately prior to Initial Election:

Death Benefit (DB)	\$100,000
Specified Amount	\$100,000
Account Value	\$30,000
Policy Debt	\$10,000
Surrender Value	\$20,000
Account Value – Policy Debt	
\$30,000 – \$10,000	

Initial Election:

Minimum Accelerated DB	\$5,000
5% of DB or \$75,000 if smaller	
Maximum Accelerated DB	\$24,000
24% of DB or \$240,000 if smaller	
Residual DB	\$10,000
5% of DB or \$10,000 if greater	
Requested Accelerated DB	\$20,000

Immediately after Initial Election:

Death Benefit	\$80,000
Reduced by Accelerated DB	
\$100,000 – \$20,000	
Specified Amount	\$80,000
Reduced by Accelerated DB / DB	
Reduced by \$20,000 / \$100,000 = 20%	
\$100,000 * (100% – 20%)	
Account Value	\$24,000
Reduced by Accelerated DB / DB	
Reduced by \$20,000 / \$100,000 = 20%	
\$30,000 * (100% – 20%)	
Debt Repayment Amount	\$2,000
Policy Debt * Accelerated DB / DB	
\$10,000 * \$20,000 / \$100,000	
Policy Debt	\$8,000
Reduced by Debt Repayment Amount	
\$10,000 – \$2,000	
Surrender Value	\$16,000
Account Value – Policy Debt	
\$24,000 – \$8,000	



LEAVE WITH APPLICANT

CONSUMER PROTECTION NOTICES FOR THE PROPOSED INSURED

Investigative Consumer Report Notice

In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You may make a written request to be interviewed in connection with the preparation of this report and receive a copy of the report. Either of these written requests should be directed to the Underwriting Department at the above address.

Insurance Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other person or organizations without your written authorization, except to the extent necessary to conduct our business, or as permitted or required by law. You have the right to be told about and obtain access to certain items of personal information in our files. You also have the right to request correction of information you believe to be inaccurate. You have the right to receive the specific reason for an adverse underwriting decision in writing upon your written request. If you would like to receive more detailed explanation of our information practices, please write to us at the above address.

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, or its reinsurers, may, however, make a brief report thereon to the MIB, INC., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

North American Company for Life and Health Insurance, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.



**NOTICE OF AIDS VIRUS ANTIBODY TESTING
AND AUTHORIZATION
FOR TESTING AND DISCLOSURE**

This document contains important information concerning the AIDS virus antibody test that we require you undergo to apply for insurance with us. It also contains information about who will have access to the information we obtain.

READ THIS NOTICE VERY CAREFULLY. DO NOT SIGN IT UNLESS IT IS COMPLETELY FILLED OUT AND YOU HAVE READ AND UNDERSTOOD IT.

You have up to 21 days from the date you receive this form to decide whether to sign this authorization.



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MODEL NOTICE OF AIDS VIRUS ANTIBODY TESTING AND AUTHORIZATION FOR TESTING AND DISCLOSURE

In connection with your insurance, your blood sample will be tested for the presence of the AIDS virus (HIV) antibody. Before consenting to this test, you are urged to read the following information about AIDS, the nature of the test and other AIDS-related information. After you read this material, you will find a request for your written authorization to be tested for the AIDS virus and for subsequent disclosure of test results. You should be aware that a positive test result may result in the denial of your insurance application.

INFORMATION ABOUT AIDS

AIDS is a condition caused by the human immunodeficiency virus (HIV). In some individuals the virus reduces the body's normal defense mechanisms against certain diseases or infections. As a result, such people often develop such unusual conditions as severe pneumonia or a rare skin cancer. The symptoms of AIDS may include the following, although other causes of these symptoms are more likely: unexplained weight loss; persistent night sweats, cough, shortness of breath, diarrhea and white spots evidencing fungal infection, fever and swollen lymph nodes lasting more than one month; and raised purple spots on or under the skin or on mucous membranes.

From medical studies, it is clear the following groups are at a high risk of contracting AIDS:

- * Past or present users of intravenous drugs
- * Males who have had sex with more than one male since the late 1970's;
- * Recipients of blood or blood products infected by the HIV virus; and
- * Sexual partners of individuals belonging to any of the above categories.

HIV ANTIBODY TEST

The HIV antibody test is actually a series of tests designed to detect the presence of antibodies to the AIDS virus rather than detect the virus itself. Antibodies to the AIDS virus are found in the blood of most patients with AIDS and AIDS-related complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus.

Your blood sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your blood specimen will then be subjected to another, more specific technique called the Western blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA tests and a Western blot test.

Positive Test Results. In general, if you receive such a positive test result, there is a high probability that you have HIV antibodies in your blood. However, there is a risk that a person who has not been exposed to the virus will be incorrectly classified by the test as having a positive test result. This is called a "false positive" result. People who are not in one of the "high risk" groups listed above who get a positive test result are much more likely to receive a "false positive" than those who are in a high risk group.

A positive test result does not mean that you have AIDS. The diagnosis of AIDS is established using a patient's history, symptoms, and physical examination. A positive test result does mean, however, that you are at risk of developing AIDS or AIDS-related conditions. It also means that, without taking precautions, you may transmit the virus to other people. Therefore, the following steps are recommended to limit the spread of AIDS: (1) stop donating blood; (2) limit sexual contacts and follow "safe sex" practices; (3) inform your sexual partners; (4) notify your doctor; and (5) if you are considering having a child, carefully evaluate the risks to the fetus.

If your test result is positive, the test result will be sent to the doctor you designate on this form, or if you prefer, we will mail the result directly to you no later than 45 days after your blood sample is taken. It is strongly recommended that you consult a physician or obtain counseling to learn more about the meaning of such a result.

Negative Test Results. If your test result is not positive, you most likely have not been infected by the virus. However, it is possible to have been infected with the virus within the past year and not yet have developed antibodies that cause a positive test result. It is possible to receive a "false negative" result.



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COUNSELING AND ALTERNATIVE TEST SITES

You may experience increased anxiety as a result of having this test performed or receiving a positive test result. Many public health organizations recommend that before a person takes an AIDS-related test, he or she obtain counseling about the test and about AIDS. A source of information about AIDS and counseling is the AIDS Action Line. In addition, the Massachusetts Department of Public Health offers free anonymous HIV antibody testing, with pre-test and post-test counseling at its Alternative Test Sites. For additional information regarding AIDS, AIDS testing or counseling, or to obtain a free, anonymous test, individuals in the high risk categories listed above are encouraged to contact the Massachusetts Department of Public Health, Alternative Test Sites for an appointment. Confidential and/or anonymous HIV antibody testing (not blood donation) and counseling is also available at various locations in Massachusetts for a fee of \$35 by appointment with the American Red Cross.

If you wait up to 21 days from the date you receive this form to decide whether to be tested, unless other circumstances relating to your eligibility change, this delay will not affect our decision to offer you insurance.

CONFIDENTIALITY

Under Massachusetts law we must treat all AIDS-related information (including test results) as highly confidential. We have established safeguards within our company that will protect the privacy of any AIDS-related information that is in your files. We have designated employees who are responsible for keeping this information confidential. We have designated certain personnel who will have access to AIDS-related information if they need the information in connection with an insurance transaction. Other personnel are aware that they are not permitted access to such information. We will make sure that AIDS-related information that is stored in a computer data bank or other files is protected by reasonable security safeguards.

To handle your insurance business, we may need to disclose your test results or other AIDS-related information to employees, reinsurers, contractors or attorneys who need AIDS-related information for underwriting, claims or another necessary business purpose in connection with your insurance transaction. These persons and entities have been informed of their clear legal obligation to maintain the confidentiality of all AIDS-related information, including test results. Similar privacy safeguards have also been adopted by the laboratory that will perform tests on your blood sample, and by any contractor, reinsurer or attorney to whom we might grant access to AIDS-related information. If we need to disclose to anyone else information about you and AIDS, we must again ask you to provide prior written consent to such disclosure. However, AIDS-related information could be disclosed without your consent in response to a subpoena. If you believe that your right to the confidentiality of any AIDS-related information about you has been violated, you should contact the Division of Insurance by writing to the Division's Consumer Services Section, 470 Atlantic Ave, Boston, MA 02210-2223.

Medical Information Bureau (MIB). If your test result is positive, we will make a report indicating a nonspecific abnormal blood test result to the Medical Information Bureau, Inc. (MIB). The nature of the test will not be reported; there will be no record with the MIB that you had a positive HIV antibody test. The MIB is a nonprofit organization of life insurance companies which operates an information exchange for its members. Our decision on whether or not to issue you a policy will not be sent to the MIB. If you later apply to another MIB member company for life or health insurance or submit a claim for life or disability insurance benefits, the MIB will, upon request, provide that company with information in its file, including information we have furnished. Otherwise the MIB will observe confidentiality safeguards similar to our own stated above. Upon your request, the MIB will arrange for disclosure to you of any information it has in your file. If you feel the information in the MIB's file is not correct, you may contact the MIB and seek a correction in accordance with the procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112. The MIB telephone number is (617) 426-3660.

DISCLOSURE AND ACCESS TO INFORMATION

If we disclose any AIDS-related information to a person or entity who is not our employee, reinsurer, attorney, or contractor as described above, or the MIB, we will notify you in writing unless we are prohibited from doing so by law or court order. Upon your written request, we will provide you, either directly, or at your option, through a physician designated by you, with copies of any information relating to you and AIDS in our



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files, for the reasonable cost of photocopying those documents. If you believe any of the information in our files is incorrect, you may write to us to request that it be corrected.

AUTHORIZATION

I have read and understand this Notice of AIDS Virus Antibody Testing and Authorization for Testing and Disclosure. I understand that: if I test positive I may be denied the insurance for which I have applied; I may experience increased anxiety as a result of having this test; the people and entities described above will or may have access to the results of my test as stated above for the purposes identified on this form; I will be given a copy of this form; and this authorization is valid for 90 days from the date of my signature below.

I authorize the drawing and testing of my blood for HIV antibodies and the disclosure of the test results as stated on this form.

NOTIFICATION OF POSITIVE TEST RESULT

In the event of a positive test result:

Please send the result to me at:

(Address) _____

I authorize North American Company for Life and Health Insurance to send the result to my physician and understand that such results may become part of my physician's permanent medical records concerning me:

(Physician's Name) _____

(Physician's Address) _____

Date: _____ Name of Individual _____

Signature of Individual _____

Date: _____ Signature of Legal Guardian, if any _____

Agent's Name and Address (who delivered this form):

(Please Print)

Laboratory customarily used where test is conducted: Lab One, Lenexa, KS.



AGENT'S REPORT

Proposed Insured's Name	Social Security Number
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1. Do the Proposed Insured and/or Applicant want to save age? Yes No
2. How well do you know the Proposed Insured? (Check all that apply) Self Relative (state relationship) _____ Met very recently
Know slightly Known well for _____ years Known through: Business Home Church Other _____
3. Was this insurance suggested by someone other than you? (If "yes," who and what prompted request?) Yes No

4. If the Proposed Insured and/or Applicant is married, give spouse's name and amount of spouse's insurance (in-force and applied for).

5. Is the Proposed Insured and/or Applicant fluent in the English language? Yes No If no, please explain how the application was completed, including the name and relationship of any translator involved in the application process.

6. What is the purpose of this insurance? Family protection Mortgage Protection Other debt retirement Estate liquidity
Business (Complete Business Supplement) Other _____

7. Is the purpose of this policy to fund college expenses? Yes No
- a. If yes, do you schedule and/or participate in college funding or planning seminars or meetings? Yes No
- b. If yes to (a), have you submitted the college planning advertising including seminar materials to the compliance department for review and approval? Yes No

8. Is the premium to be paid by a party other than the Proposed Insured? (If yes, please explain.) Yes No

9. Did you personally see all Proposed Insureds at the time the application was written? (If no, please explain.) Yes No

10. Did you ask each question on the application for each Proposed Insured and witness all signatures? (If no, please explain.) Yes No

11. What underwriting requirements have you scheduled? Paramed Exam and HOS DBS, HOS SMA EKG MD Exam Treadmill EKG
Other _____ Examiner Name _____ Telephone Number _____

The answers given in the Agent's Report are complete and true to the best of my knowledge and belief. I have delivered the receipt and any notices required in this state, as applicable, to the Proposed Insured and/or Policy Owner. I certify that only sales materials approved by North American Company for Life and Health Insurance were used in conjunction with this transaction, and copies of all sales materials were left with the applicant. I recommend each Proposed Insured for the insurance applied for.

Signature of Agent	Agent Code Number	Date
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GENERAL PURPOSE LIFE APPLICATION Part I (Print and Use Black Ink)

PRIMARY INSURED PROPOSED FOR INSURANCE

1. Last Name	First Name	M.I.
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1a. Are you a U.S. Citizen or do you have a permanent Visa? Yes No (If no, complete Foreign Travel and Residence Questionnaire)

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Place of Birth - State / Country	Height (FT. IN.)	Weight (LBS.)	Marital Status
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Social Security Number/Tax ID#	Driver's License Number	Expiration Date	State
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2. Residence Address (If P. O. Box include Street Address)	Street	City	State	Zip Code
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2a. How long at this address? (If less than 2 years, provide previous address.)

_____ Years _____ Months

2b. Billing Address (If other than residence)	Street	City	State	Zip Code
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2c. Secondary Addressee Billing Yes No If Yes, Provide Secondary Addressee's Name, Street Address, City, State & Zip Code
(Agent cannot qualify as Secondary Addressee)

3. Employer (Company Name and Address)

Occupation (Title and Duties)	Annual Income \$	Net Worth \$
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4. Contact The Proposed Insured At: <input type="checkbox"/> Residence _____ (CST) <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Business _____	Residence Telephone Number: Primary Insured () Additional Insured () Cell Phone ()	Business Telephone Number: Primary Insured () Additional Insured () Cell Phone ()
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PLAN INFORMATION

5. Amount Applied For \$	Proposed Plan of Insurance	6. For UL: (check if applicable) <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Return of Premium
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7. RIDERS

<p>a. Term Products</p> <p><input type="checkbox"/> Additional Insured Rider \$ _____</p> <p><input type="checkbox"/> Children's Term Insurance Rider (CTR) _____ units</p> <p><input type="checkbox"/> Guaranteed Insurability Rider _____ units</p> <p><input type="checkbox"/> Monthly Income Endorsement: Initial Lump Sum \$ _____ \$ _____ Monthly for _____ years; Final Lump Sum \$ _____</p> <p><input type="checkbox"/> Waiver of Premium Rider</p> <p><input type="checkbox"/> Other _____ \$ _____</p>	<p>b. Permanent Products</p> <p><input type="checkbox"/> Accidental Death Benefit \$ _____</p> <p><input type="checkbox"/> Additional Insured Rider \$ _____</p> <p><input type="checkbox"/> Automatic Distribution Option</p> <p><input type="checkbox"/> Children's Term Insurance Rider (CTR) _____ units</p> <p><input type="checkbox"/> Estate Preservation Rider</p> <p><input type="checkbox"/> Guaranteed Insurability Rider _____ units</p> <p><input type="checkbox"/> Premium Guarantee Rider</p> <p><input type="checkbox"/> Waiver of Monthly Deductions Rider</p> <p><input type="checkbox"/> Waiver of Surrender Charge Option</p> <p><input type="checkbox"/> Other _____ \$ _____</p>
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ADDITIONAL INSURED PROPOSED for INSURANCE (Complete Separate Application for Business Associates and Additional Insureds)									
8. Last Name			First Name				M.I.		
8a. Are you a U.S. Citizen or do you have a permanent Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, complete Foreign Travel and Residence Questionnaire)									
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		Age	Place of Birth - State / Country		Height (FT. IN.)	Weight (LBS.)	Relationship to Insured	
Social Security Number/Tax ID#			Driver's License Number			Expiration Date		State	
9. Employer (Company Name and Address)									
Occupation (Title and Duties)								Annual Income \$	
10. DEPENDENT CHILDREN PROPOSED for INSURANCE									
Name	Date of Birth	Place of Birth State/Country	Age	Sex	Social Security Number/Tax ID#	Height (FT. IN.)	Weight (LBS.)	Relationship to Proposed Insured	
11. OWNER INFORMATION (Complete only if other than Proposed Primary Insured)									
Name of Owner(s): If Trust, list all Trustees as well as Name and Date of Trust and complete Trust Form . If Owner is a business, complete Company/Corporate Owned Life Insurance (COLI) Form .									
Owner's Address		Street			City		State		Zip Code
Relationship to Primary Insured		Owner's Social Security/Tax ID #			<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Resident Alien - Country _____ <input type="checkbox"/> Nonresident Alien - Country _____				
Name of Contingent Owner(s)					Contingent Owner's Social Security/Tax ID #				
12. PRIMARY BENEFICIARY									
If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)									
Name		Percent	Relationship to Proposed Primary Insured			Social Security Number/Tax ID#			
Total		100	Beneficiary designations do not apply to others covered under Children's Insurance Riders.						
13. CONTINGENT BENEFICIARY									
If percentage shares are not listed below, they will be divided equally among the beneficiaries. Provide Beneficiary(ies) Full Name(s) (If Trust, list Name and Date of Trust and complete Trust Form)									
Name		Percent	Relationship to Proposed Primary Insured			Social Security Number/Tax ID#			
Total		100							
14. Has anyone proposed for insurance ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes? Respond Below:									
14a. Proposed Primary Insured: <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', provide: Type of product(s) used _____ Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____									
14b. Additional Insured Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', provide: Type of product(s) used _____ Amount Used: _____ How often: Daily _____ Weekly _____ Monthly _____ Date of last use: mm/yy _____									

PREMIUM INFORMATION

15. Premium Frequency: Annual Semi-Annual Quarterly Monthly Single Pay Lump Sum \$

Premium Mode: EFT List Billing Direct Billing (A, SA, Q) only Civil Service Allotment Military Government Allotment

List Bill Code _____ Other _____

For term and whole life policies, if you elect to pay premium on a basis other than annual, you may pay more premium than would be required if you paid premium on an annual basis.

Amount of Modal Premium \$ Amount Paid with Application \$

Make all checks payable to: NORTH AMERICAN COMPANY FOR LIFE & HEALTH INSURANCE

16. For EFT Only: Draw Day _____ (1 st - 28 th) Month _____ Day _____	Account Type <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings (must complete 16b)	Authorized Signature(s) of Account Holder(s) X
16a. Initial Draft <input type="checkbox"/> Yes <input type="checkbox"/> No		X
16b. Routing Transit Number	Account Number	Financial Institution Name and Address

REPLACEMENT INFORMATION

17. Does any person proposed for coverage have any life insurance or annuities currently in force or pending? (This includes policies that have or will be sold, assigned or otherwise placed via life settlement, viatical or other agreements.) Yes No If yes, list below:

Name	Company	Policy #	Pending	Issue Yr.	Basic Amount	ADB Amount	WP Amount	Intention of Replacement or Change*
17a.			<input type="checkbox"/>					18a. <input type="checkbox"/> Yes <input type="checkbox"/> No
17b.			<input type="checkbox"/>					18b. <input type="checkbox"/> Yes <input type="checkbox"/> No
17c.			<input type="checkbox"/>					18c. <input type="checkbox"/> Yes <input type="checkbox"/> No
17d.			<input type="checkbox"/>					18d. <input type="checkbox"/> Yes <input type="checkbox"/> No

***Replacement means that the insurance applied for may replace, change or use any value of an existing or pending life insurance policy or annuity. If replacement may be involved, complete applicable replacement form and submit with application. If this is a 1035 Exchange, also complete 1035 Exchange paperwork and submit with application.**

19. Are any of the above policies being used to fund this policy? Yes No
20. Has, or will, any person proposed for insurance, or owner of this policy, been compensated in any way to purchase this policy? Yes No
21. Is the proposed insured(s), or owner of this policy, paying for this policy with his/her own funds? Yes No
22. Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy? Yes No
23. Has any person proposed for insurance, or owner of this policy, financed, or intend to finance, all or a portion of the premiums for this policy? If yes, complete Disclosure and Acknowledgement Form for premium financing and submit with application Yes No
24. Has the policy owner, beneficiary, or person proposed for insurance entered into or considering any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests? Yes No

If the answer is 'Yes' to questions 19, 20, 22 or 24 provide details below. If answer to question 21 is 'No' provide details below.

TO BE COMPLETED BY SOLICITING AGENT

Does any person covered under this application have any existing life insurance or annuities?..... Yes No

Is any insurance applied for in this application intended to replace any existing life insurance or annuity?..... Yes No

If the policy being applied for includes an accelerated death benefit(s), the agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application?..... Yes No

If a replacement is involved, the application Replacement Notice will be sent to the existing insurer. Leave the applicant a copy of all sales materials used in the sales presentation

Questions 34 through 37 must be completed for all proposed insureds, including CTR, not subject to a full paramedical exam. Details to "Yes" answers are to be provided in the Details Section below.

34. In the past 10 years, has any person proposed for insurance been diagnosed by a licensed medical professional, treated or advised to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):
- | | Yes | No |
|--|--------------------------|--------------------------|
| (a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, poor circulation, valvular heart disease, cardiomyopathy or heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) High blood pressure, hypertension or abnormal cholesterol levels? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Stroke, seizures, epilepsy, dizziness, fainting, memory disorder or any other neurological or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Diabetes, abnormal blood sugar, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia, hemophilia, clotting disorder or any other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Immune Deficiency disorder (Acquired Immune Deficiency Syndrome (AIDS)), AIDS related complex (ARC) or been told test results indicate exposure to the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, liver failure, liver impairment, loss of bowel function or other disease or disorder of the liver or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Depression, anxiety, stress, eating disorder or any other nervous, mental or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Any mental or physical disorder or medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
35. Other than indicated above, has any person proposed for insurance:
- | | | |
|--|--------------------------|--------------------------|
| (a) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death. | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) In the past 12 months been advised by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) In the past 12 months been advised by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility? | <input type="checkbox"/> | <input type="checkbox"/> |
36. Is any person proposed for insurance currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken..... Yes No
37. Is any person proposed for insurance currently receiving or have an application pending for any illness or disability benefits or compensation?

DETAILS TO 'YES' ANSWERS FOR QUESTION 34 THROUGH 37

Question #	Proposed Insured's Name	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital

38. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years for each person proposed for coverage.

a. Date and findings of last visit:	
b. Tests performed and treatment received:	

CUSTOMER IDENTIFICATION				
Indicate the form of ID presented and used to verify this owner's identity:				
A. Owner #1				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
<i>Non-Natural/Business or Corporation</i>				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	
B. Owner #2				
Natural Person/Trust Accounts (info on trustee)				
	Driver's License	State:	Number:	Expiration Date:
	State-issued ID	State:	Number:	Expiration Date:
	Military ID		Number:	Expiration Date:
	Passport	Country:	Number:	Expiration Date:
	Alien Registration Card	Country:	Number:	Expiration Date:
<i>Non-Natural/Business or Corporation</i>				
	Partner or Trust Agreement		Date:	
	Certificate of Incorporation	State:	Date:	
	Business License	State:	Number:	

IT IS DECLARED that statements and answers in this application, including statements by the Proposed Insured(s) in any medical questionnaire or supplement that become part of this application, are complete and true to the best knowledge and belief of the undersigned. IT IS AGREED THAT: (1) any waiver or modification of this application will not be effective unless in writing and signed by the President, or the Secretary of our Company; (2) the acceptance of any policy issued on this application shall constitute a ratification of any correction or amendment made by the Company. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the applicant(s). The undersigned FURTHER AGREES to immediately advise the Company of any change to any of the responses contained in the application, including any change in the health or habits of any Proposed Insured(s), that arises or is discovered after completing this application, but before the Policy is effective, as defined herein.

Effective Date - Any insurance issued as a result of this application will either: (1) not take effect until the full first premium is paid and the contract is delivered to and accepted by the Owner during the lifetime of any person proposed for insurance and while such person is in the state of health described in all parts of this application; or (2) take effect only as specified in the Temporary Insurance Agreement, if issued.

Payment of Premium - (check one) This application is C.O.D.; I have elected initial EFT or I have paid \$ _____ with this application in consideration of a Temporary Insurance Agreement. I have read, understand, and agree to the terms of the Temporary Insurance Agreement.

The undersigned applicant(s) acknowledges receipt of the Fair Credit Reporting Act Notice/MIB, Inc. Notice and Notice of Insurance of Information Practices.

TAX PAYER IDENTIFICATION NUMBER CERTIFICATION - Under penalties of perjury, the undersigned applicant(s) (I) certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding. **(Please check appropriate response.)**

FINANCIAL INSTITUTION DISCLOSURE - Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to North American Company for Life and Health Insurance (the Company) or its legal representative, any and all such information. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months from the date signed. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Accelerated Death Benefit: If the policy being applied for includes an accelerated death benefit(s), the Proposed Primary Insured understands and acknowledges: (1) Receipt of such benefits may affect eligibility for public assistance programs and benefits may be taxable; (2) Payment of this benefit will reduce the Insured's death benefit; (3) There is no additional premium for this benefit; and (4) The agent provided the Proposed Primary Insured the Accelerated Benefit Summary and Disclosure Statement(s) prior to or concurrent with this application.

SIGNATURES				
Signed At (City, State)			Date	
Signature of Proposed Primary Insured (If 15 Years or Older), or Legal Guardian (If Primary Proposed Insured is a Minor)		Signature of Proposed Additional Insured		
X		X		
Signature of Owner (If other than Proposed Primary Insured) (If Owner is Corporation, Trust, or other Entity, include Title of Signee.)				
X				
Signature of Soliciting Agent		Print Agent's Last Name	Agent Code	Telephone Number ()
X				Cell Phone Number ()
Other Agent (Print)			% Credit	Agent Code
Other Agent (Print)			% Credit	Agent Code



Authorization for Release of Health-Related Information

Send Information to: New Business & Administrative Office
One Sammons Plaza, Sioux Falls, SD 57193

This Authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured _____
(Please print)

Birth Date _____ / _____ / _____
Month Day Year

I authorize any health plan, physician, dental practitioner, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The North American Company for Life and Health Insurance and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that North American Company for Life and Health Insurance may: 1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with North American Company for Life and Health Insurance .

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to North American Company for Life and Health Insurance at One Sammons Plaza, Sioux Falls, SD 57193, Attention: New Business. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that North American Company for Life and Health Insurance has a legal right to contest a claim under an insurance policy or to contest the policy itself.



I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that My Providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this Authorization to release my complete medical record, North American Company for Life and Health Insurance the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this authorization.

Signature of Proposed Insured or Personal Representative

Date (MM/DD/YYYY)

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:



TRANSMITTAL REPORT

Gold Team Phone: 800-669-9100 Fax: 800-951-9430 email: nbgold@nacolah.com
Purple Team Phone: 866-606-2943 Fax: 800-978-7959 email: nbpurple@nacolah.com

PLEASE PRINT

Agency Name		Producer Code		Contact Person/E-mail Address	
Address				Fax Number	
City	State	Zip Code	Phone No.		
Writing Agent	Phone No.		Agent Code		

Proposed Insured (1)		
Proposed Insured (2)		
Plan of Insurance	Face Amount (1)	Face Amount (2)
PREMIUM SUBMITTED \$ _____ Please attach a copy of Illustration		

<p>Please indicate by placing an O if ordered or A if attached next to the requirement.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Proposed Insured (1)</th> <th style="text-align: left;">Requirement</th> <th style="text-align: left;">Proposed Insured (2)</th> </tr> </thead> <tbody> <tr><td>_____</td><td>Paramedical Exam</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Physical Measurements/Vitals</td><td>_____</td></tr> <tr><td>_____</td><td>MD Exam</td><td>_____</td></tr> <tr><td>_____</td><td>EKG</td><td>_____</td></tr> <tr><td>_____</td><td>Treadmill</td><td>_____</td></tr> <tr><td>_____</td><td>APS Dr. _____</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Vendor Name _____</td><td>_____</td></tr> <tr><td>_____</td><td>APS Dr. _____</td><td>_____</td></tr> <tr><td>_____</td><td>Date ordered _____</td><td>_____</td></tr> <tr><td>_____</td><td>Vendor Name _____</td><td>_____</td></tr> <tr><td>_____</td><td>Confidential Financial Statement</td><td>_____</td></tr> <tr><td>_____</td><td>Urine/HIV</td><td>_____</td></tr> <tr><td>_____</td><td>Full Blood Profile</td><td>_____</td></tr> <tr><td>_____</td><td>Replacement Forms</td><td>_____</td></tr> <tr><td>_____</td><td>Illustration</td><td>_____</td></tr> <tr><td>_____</td><td>Cover Letter</td><td>_____</td></tr> <tr><td>_____</td><td>Underwriter Checklist</td><td>_____</td></tr> <tr><td>_____</td><td>Other (describe) _____</td><td>_____</td></tr> </tbody> </table>	Proposed Insured (1)	Requirement	Proposed Insured (2)	_____	Paramedical Exam	_____	_____	Date ordered _____	_____	_____	Physical Measurements/Vitals	_____	_____	MD Exam	_____	_____	EKG	_____	_____	Treadmill	_____	_____	APS Dr. _____	_____	_____	Date ordered _____	_____	_____	Vendor Name _____	_____	_____	APS Dr. _____	_____	_____	Date ordered _____	_____	_____	Vendor Name _____	_____	_____	Confidential Financial Statement	_____	_____	Urine/HIV	_____	_____	Full Blood Profile	_____	_____	Replacement Forms	_____	_____	Illustration	_____	_____	Cover Letter	_____	_____	Underwriter Checklist	_____	_____	Other (describe) _____	_____	<p>Please complete the following:</p> <p><input type="checkbox"/> BCX</p> <p><input type="checkbox"/> TeleMed Interview. (The best day, time and number to call must be indicated on Part I of the application).</p> <p><input type="checkbox"/> No TeleMed Interview (Complete Entire Application)</p> <p>POLICY NUMBER: _____ (if applicable)</p> <p>HAS THIS APPLICATION BEEN FAXED ? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "No" please mail to:</p> <p style="text-align: center;">New Business Department North American Company One Sammons Plaza Sioux Falls, SD 57193</p> <hr/> <p>Special Requests/Remarks (i.e. Policy Date, Trust Date, 1035 Information etc. Include cover letter for financial justification or special circumstances)</p>
Proposed Insured (1)	Requirement	Proposed Insured (2)																																																														
_____	Paramedical Exam	_____																																																														
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_____	Underwriter Checklist	_____																																																														
_____	Other (describe) _____	_____																																																														

Date submitted: _____

By: _____



L16831

Electronic Fund Transfer Authorization

Attach one preprinted, blank, voided check

Step 1. Applicant/Insured (Last Name, First, M.I)	Social Security No.	Policy Number (if known)
	- -	
	- -	

Step 2A. New Applicants - Select Option

Payment Frequency Monthly; Quarterly; Semi-annually

Payment Option 1: Deduct the **first and future** premium payments. (The first deduction will occur on or after the policy date and then at the intervals selected above.)

Payment Option 2: Deduct **future** premium payments only. (The initial premium payment is to be made by check. The day of the month in your policy date will be used to initiate future deductions at the intervals indicated above. Or, you may choose a specific day of the month between the 1st and 28th _____. Premium is due on or before the due date. For monthly deductions, selecting a day of the month that is after the policy day may initially result in deductions to pay both the current month and next month premiums.)

Address Change New Address _____

Step 2B. Existing Policy Owners/Payers

a. Payment Frequency Monthly; Quarterly; Semi-annually

b. Withdrawal Day of the Month (1st - 28th only): _____ Beginning: _____ MM/YY
(Note: If a specific day of the month is not indicated, the day in your policy date will be used. Premium is due on or before the due date. For monthly deductions, selecting a day of the month that is after the policy day may initially result in deductions to pay both the current and next month premiums.)

c. Withdrawal Amount: \$ _____ (For flexible premium policies only.)

d. Loan repayment amount: \$ _____ (Note: requires a minimum of \$1.00 billed for premium.)

Step 3. Financial Institution Information Routing Transit No. (if known) _____

Bank Name _____ Account No. _____

Account Holder (Payer) Name (Please print.) _____

Enclose one preprinted, blank, voided check

Step 4. Authorization

I authorize the Company to initiate an automatic electronic payment from my account indicated above at the financial institution (Bank) indicated above and I authorize my Bank to honor the withdrawal(s). I authorize the adjustment of the dollar amount transferred from my account to correspond to periodic changes in the payment due under the terms of the policy. I understand that this authorization is to remain in effect until cancelled in writing either by me, the Company, or the Bank. Notice of five business days is required to change or terminate this authorization.

Payer Signature _____ Date _____

Terms and Conditions

If your automatic payment is to be taken on a weekend or holiday, such payment will be deducted on the next business day. Information as to each charge will be provided by an entry on your bank statement or by other advice from the bank. Deductions will be made on or about (after) the date requested. In the event a charge is inadvertently not made, the Company may charge the account at a later date. You will be notified prior to an increase in the deduction which may occur due to periodic changes in the premium due under the terms of the policy, if any. The Company may terminate this payment method if any charge is not paid upon presentation, or if more than two changes are requested in any 12 month period.

FOR OFFICE USE ONLY
Processed by: _____ Date: _____ Control #: _____



TEMPORARY LIFE INSURANCE AGREEMENT

Proposed Primary Insured	Proposed Additional Insured(s)
--------------------------	--------------------------------

Premium, authorization for initial EFT draft or credit card authorization has been received from _____ in the amount of \$_____ in payment of one full monthly premium for an insurance policy applied for on the life (lives) of the above named (Proposed Primary Insured/Proposed Additional Insured(s)), for whom an application (the "Application") dated _____ has been made to North American Company for Life and Health Insurance (the "Company"). **This Temporary Life Insurance Agreement does not provide any coverage except as provided herein. If any of the below representations are answered YES or LEFT BLANK, the agent is not authorized to accept any premium, authorization for initial EFT draft or credit card authorization, and there will be NO COVERAGE. There will also be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal.**

I. REPRESENTATIONS

- | Has any person listed above as a Proposed Primary Insured or Proposed Additional Insured(s): | Yes | No |
|---|--------------------------|--------------------------|
| 1. In the past five years, been diagnosed, treated for, or been advised to be treated for: heart disease; vascular disease; stroke; cancer; leukemia; malignant tumor; alcohol or drug dependence or abuse; insulin dependent diabetes; or disorder of the brain or immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. In the past five years, had any unintentional weight loss or any symptoms of a disease or an impairment for which a physician has not been consulted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test that has not been completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past ten years, been convicted of any criminal activity, or been held or served time in any type of incarceration, jail, penitentiary, prison, probation, or parole program? Or have any criminal charges pending against him/her at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person proposed for insurance under 15 days of age or over 70 years of age? | <input type="checkbox"/> | <input type="checkbox"/> |

II. TERMS AND CONDITIONS

1. AMOUNT OF COVERAGE APPLIED FOR: \$1,000,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If one full monthly premium for the insurance applied for in the application for life insurance has been received as consideration by the Company from the Proposed Owner as advance payment for the life insurance and a Proposed Insured(s) dies while this Agreement is in effect, upon receipt of due proof of death, the Company will pay to the designated beneficiary the LESSER of

- (a) the amount of all death benefits applied for in the Application; or
- (b) \$1,000,000.

This total benefit applies to all insurance applied for under this and any other applications to the Company including any other temporary life insurance agreements.

2. DATE TEMPORARY COVERAGE BEGINS

Any temporary insurance under this Agreement will begin on the date the application is signed only if the Application is completed and signed by the Proposed Insured(s) and the Proposed Owner bearing the same date as this Temporary Life Insurance Agreement; one full monthly premium is collected; and all of the questions in the above Section of this Temporary Life Insurance Agreement are truthfully and completely answered "NO".

3. DATE TEMPORARY COVERAGE TERMINATES

The Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

- (a) 90 days from the date the Application was signed;
- (b) the date that insurance takes effect under the insurance contract(s) as applied for in the Application;
- (c) the date an insurance contract(s) other than as applied for in the Application, is offered to the Proposed Owner; or
- (d) the date the Company mails notice of termination of coverage and refunds the advance premium payment to the Proposed Owner at the address shown in the Application. The Company may cancel this coverage at any time.

4. SPECIAL LIMITATIONS

- (a) Fraud or material misrepresentation in the Application or in this Agreement shall invalidate this Agreement and the Company's only liability is to refund any advance premium payment made.
- (b) There is no insurance under this Agreement if the check, initial EFT draft or credit card authorization is not honored when presented.
- (c) If the Proposed Insured(s) dies by suicide, the Company's liability under this Agreement is limited to a refund of any advance premium payment made.
- (d) No agent or other person is authorized to accept money on a Proposed Insured under 15 days of age or over 70 years of age (age nearest birthday) from the date of this Agreement, nor will any insurance take effect for such person.
- (e) No agent is authorized to modify any of the provisions of this agreement.
- (f) The total of the amount payable under this and any other Temporary Life Insurance Agreement or application with the Company will not exceed \$1,000,000 for each life proposed for insurance.

5. General

Premium(s) will be returned if a policy is not delivered and no benefit is paid under this Agreement. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the delivery date premiums will be based on the policy date.

I, the PROPOSED OWNER/PRIMARY INSURED/ADDITIONAL INSURED(S), declare that I have fully read and understand all the questions and the answers given in this Agreement and the Application and, that the answers I gave are true and complete. I, the Proposed Owner, agree that they are to be relied on for this coverage and declare that I have received a copy of this Agreement and that I have read and understand this Agreement. I agree to all the provisions, terms and limitations of this Agreement and acknowledge that I do not expect any insurance to become effective based on the application or under this Agreement other than as stated in the application and in this Agreement. I agree to be bound by all the answers, statements, and representations made in the Application and this Agreement.

Proposed Owner Name (Print)		Date
Proposed Owner Signature	Signed At (City/State)	
Proposed Primary Insured Name (if other than owner) (Print)		Date
Proposed Primary Insured Signature	Signed At (City/State)	
Proposed Additional Insured Name (Print)		Date
Proposed Additional Insured Signature	Signed At (City/State)	
Agent Name (Print)		Agent Phone Number
Agent Signature		Date

All premium checks must be made payable to **North American Company for Life and Health Insurance**. Do not make checks payable to the agent or leave the payee space blank. **No agent or other person is authorized to accept money on any application in excess of \$1,000,000. A temporary life insurance agreement cannot be accepted on any application in excess of \$1,000,000.**